Medicaid Enterprise

Iowa Department of Human Services

Prescribed Drugs

Provider Manual

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Iowa Department of Human Services

III. Provider-Specific Policies

4. Prior Authorization Response

The pharmacist reviewer will make a decision and respond within 24 hours of the request. In evaluating requests for prior authorization, the reviewer will consider the drug from the standpoint of published criteria only.

If a prior authorization request is denied, a letter of denial will be faxed to both the prescriber and the pharmacist. A letter of denial will be mailed to the member.

Upon approval of a prior authorization request, a letter of approval will be faxed to the prescriber and the pharmacy indicating the prior authorization number and dates of authorization.

NOTE: When approval of a request is granted, this does not indicate validity of the prescription, nor does it indicate that the member continues to be eligible for Medicaid. If you are not billing on the point-of-sale system, it is your responsibility to establish that the member continues to be eligible for Medicaid, either by:

- Calling the eligibility verification system (ELVS) at (515) 323-9639 (local calls) or 800-338-7752; or
- Checking the IME web portal; http://ime-ediss.noridian.com/iowaxchange/

D. BASIS OF PAYMENT FOR DRUGS AND SUPPLIES

The amount of payment for drugs and supplies is based on several factors, in accordance with 42 CFR 447.331-447.332 and 441 IAC 79.1(8).

"**Estimated acquisition cost**" (**EAC**) is defined as the average wholesale price (AWP) as published by Medi-Span less 12%.

"**Maximum allowable cost**" (**MAC**) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services, as described in 42 CFR 447.332(a)(i) and (ii).

"**State maximum allowable cost**" (**SMAC**) reimbursement is assigned to certain drug products meeting therapeutic equivalency, market availability, or other criteria determined appropriate by the Department. SMAC fees are based on the prices at which affected drugs are widely and consistently available to pharmacy providers enrolled in the Iowa Medicaid program, adjusted by a multiplier of 1.4.

The Department has discretion to establish and apply SMAC fees to drugs, determine criteria for drugs subject to the SMAC, adjust SMAC fees or other policy or procedural elements of the SMAC, or otherwise direct the SMAC program in accordance with applicable state and federal law.

For drugs with no established MAC or SMAC, the Department determines the allowable estimated acquisition cost in accordance with the provisions of federal drug regulation 42 CFR 447.331(b). This basis of payment is also applicable to compounded prescriptions.

Reimbursement for covered **generic** prescription drugs shall be the lowest of the following, as of the date of dispensing:

- The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee.
- The maximum allowable cost (MAC) plus the professional dispensing fee.
- The state maximum allowable cost (SMAC) plus the professional dispensing fee.
- The submitted charge, representing the provider's usual and customary charge for the drug.

Reimbursement for covered **brand-name** prescription drugs shall be the lowest of the following, as of the date of dispensing:

- The estimated acquisition cost plus the professional dispensing fee.
- The submitted charge, representing the provider's usual and customary charge for the drug.

The Medicaid program relies on information published by Medi-Span to classify drugs as brand or generic.

1. Drugs Subject to Maximum Allowable Cost (MAC)

The Centers for Medicare and Medicaid Services establishes federal upper limits (FUL) for reimbursement for multiple-source drugs. These reimbursement levels are updated periodically and are available on the Centers for Medicare and Medicaid Services web page at http://www.cms.hhs.gov/FederalUpperLimits/.

2. Drugs Subject to State Maximum Allowable Cost (SMAC)

The Department of Human Services established a state maximum allowable cost (state MAC) in response to 2001 Iowa Acts, Chapter 191, section 31. The state MAC is defined as the average acquisition cost for a drug and all equivalent products adjusted by a multiplier as determined by the Iowa General Assembly.

State MAC rates will be set for selected products for which an appropriate number of "A" rated therapeutically equivalent alternatives are available. The SMAC list can be viewed at http://mslciowa.com/. The Department is directed to update the state maximum allowable cost every two months, or more often if necessary, to ensure adequate product availability.

Pharmacies and providers that are enrolled in the Iowa Medicaid program shall submit drug acquisition cost information or product availability information to the Department or its designee to assist the Department in monitoring and revising reimbursement rates and for the efficient operation of the pharmacy benefit.

3. Reimbursement for MAC and SMAC Drugs

For the drug groups on the Preferred Drug List where brand-name products are preferred over generic products, the FUL/SMAC rate will continue to apply when the generic version of the drug is dispensed.

However, the payment for preferred brand name products (which no longer require prior authorization before dispensing) equals the lower of estimated acquisition cost (average wholesale price less 12%) or the submitted charges, as opposed to the FUL/SMAC rate.

Nonpreferred brand products require prior authorization before dispensing. If authorized, payment equals the lower of the estimated acquisition cost (average wholesale price less 12%) or the submitted charges, as opposed to the FUL/SMAC rate with a prior authorization. The DAW=1 is no longer required for brand reimbursement.

Prior authorization is required for selected brand-name drugs as determined by the Department for which there is available, an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration.

For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed form 470-4119, *Request for Prior Authorization: Selected Brand Name Drugs*, shall be considered as evidence of treatment failure.

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list and the State Maximum Allowable Cost (SMAC) list at http://www.mslciowa.com/. Prior authorization **is not required** for brand name drugs that have been designated by the Department as **preferred** (payable) under the Iowa Medicaid Preferred Drug List (PDL).

4. Reimbursement for Unit-Dose Packaging

Additional reimbursement of one cent per dose, added to the ingredient cost, is available for dispensing oral solids to nursing home patients in unit-dose packages prepared by the pharmacist. Unit dose reimbursements are permitted only for patients with Plan 300 eligibility.

Claim the additional reimbursement by placing a "3" in "Unit Dose Indicator" (field 429-DT) for electronic claims, as explained under POINT OF SALE BILLING SYSTEM, or a "09" in the Basis Cost (field 14) on the paper claim form, as explained under PAPER CLAIM BILLING INSTRUCTIONS. The additional reimbursement will be automatically added, possibly resulting in reimbursement that is higher than your submitted charge.

Credits: Payment may be made only for unit-dose-packaged drugs that are **consumed** by the patient. Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the Medicaid program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the drug cost component.

In accordance with state and federal law, proper crediting to Iowa Medicaid is **required** for the return of unused medications upon therapy discontinuation or a member's discharge, transfer, or death.